

# Type Two Diabetes and Hypertension Evaluation Sheet page 1

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Smoking history Yes \_\_\_\_\_ No \_\_\_\_\_

Medical History:

\_\_\_\_\_

Family Medical History:

\_\_\_\_\_

	<u>Age</u>	<u>Current Health</u>	<u>Cause/Age of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Brother (s)	_____	_____	_____
Sister (s)	_____	_____	_____

Coronary Risk Factors:

\_\_\_\_\_

Blood Pressure Readings (all three must be completed)

Date \_\_\_\_\_ B/P \_\_\_\_\_/\_\_\_\_\_ Where taken \_\_\_\_\_

Date \_\_\_\_\_ B/P \_\_\_\_\_/\_\_\_\_\_ Where taken \_\_\_\_\_

Date \_\_\_\_\_ B/P \_\_\_\_\_/\_\_\_\_\_ Where taken \_\_\_\_\_

Date of Resting ECG \_\_\_\_\_ (please submit with this form if required by FAA)

If Stress Test done, please indicate date done here and results

\_\_\_\_\_

Labs: FBS \_\_\_\_\_ Tot. Cholesterol \_\_\_\_\_ LDL \_\_\_\_\_  
HDL \_\_\_\_\_ Triglycerides \_\_\_\_\_ Creatinine \_\_\_\_\_  
Potassium \_\_\_\_\_

Labs: Hemoglobin A1C within last 30 days, or last 90 days if certification renewal

Date \_\_\_\_\_ Value \_\_\_\_\_

Date \_\_\_\_\_ Value \_\_\_\_\_

Current Medications:

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Rx \_\_\_\_\_ Dosage \_\_\_\_\_ Sig \_\_\_\_\_

Medication Side Effects/clinically sig. Hypoglycemic Reaction? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what? \_\_\_\_\_

**Type Two Diabetes and Hypertension Evaluation Sheet page 2**

I certify there is no evidence of cardiovascular, neurological, renal and/or ophthalmological disease AGREE / DISAGREE If disease noted, please comment in Medical History Section near the top of the page.

Treating Physician:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/Zip Code \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_